Health Reform Ideas for North Carolina (January 14, 2014)

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North Carolina needs a health reform strategy that is developed by and for the people of North Carolina. Any realistic approach will acknowledge and even embrace the fact that we will never be finished with something so important: addressing the related issues of coverage, cost and quality.

Our State has a history of addressing difficult problems in a straightforward manner. We can do so again, but only if members of both political parties (and those with no party affiliation) work together to develop practical solutions that will outlast the current balance of political power in Raleigh and Washington. We have a chance to be a national leader in health reform by charting bold changes that build upon our strengths, and committing to learning from the results.

This paper is meant to be a conversation starter. In that spirit, I suggest three areas of reform:

Expand Health Insurance Coverage While Reforming Medicaid

- North Carolina should run our own health insurance exchange or marketplace, and
- Seek both a Medicaid waiver and develop a "Basic Health Plan" under section 1331 of the ACA that will allow our state to greatly expand insurance coverage for persons between 0 and 200% of poverty under advantageous financial terms.
- Persons below 100% of poverty could be auto-enrolled into the lowest cost Basic Health Plan (BHP) in their county; those between 101%-200% of poverty could choose among multiple private plans with premiums based on a sliding fee scale.
- Move ahead with a regionalized Medicaid delivery system reform that builds upon our state's great teaching and referral hospital and health care systems as well as Community Care North Carolina (CCNC).

Reform the State's Medical Malpractice System while Addressing Patient Safety

- Pilot a new medical malpractice/patient safety approach in the existing Medicaid program and BHP suggested above; if successful, the experience could be a model for the entire state. The key is addressing both medical malpractice and patient safety.

Increase the Supply of Health Care Providers by Safely Reducing Regulation

- Increase the supply of health care providers by safely reducing regulation and expanding the license/practice authority of non-physician providers

I. Expand Health Insurance Coverage While Reforming Medicaid

North Carolina should develop our own health care marketplace (exchange) through which private health insurance available through the Affordable Care Act can be sold. We can a do a better job of this than the Federal Government has done with healthcare.gov, making it easier for our citizens to shop and decide if they want to purchase coverage or pay the tax penalty. There is an inevitable movement toward an exchange based health insurance approach, and we might as well begin doing this for ourselves to better position our State for the future. Finally, creating our own exchange will give our State an opportunity to encourage other insurance providers to enter the North Carolina marketplace; alternatively, we could view Blue Cross/Blue Shield essentially as a public utility.

The key to reforming Medicaid is understanding the very different needs and costs of the different groups of our fellow citizens covered by the program. If I could make one wish for health reform, it would be that everyone would understand that Medicaid is not one monolithic program. Adults and children are numerous in Medicaid (over half the beneficiaries), but the dual eligibles (covered by Medicare and Medicaid) and disabled are far more expensive. It should be noted that the potential Medicaid expansion would primarily add childless adults in North Carolina, persons whose costs are likely to be similar to those of other covered adults, and much lower than the costs for the disabled and dual eligibles.

Distribution of Medicaid Enrollees by Eligibility Category and Payment, 2009

	Medicaid Beneficiaries		Medicaid Payments		
North Carolina	N	% enrollees	$ Total (Billions)	% Payments	$ Per Capita
Aged	182,422	10	1.946	18	10,664
Disabled	309,097	17	4.961	45	16,050
Adults	360,852	20	1.464	13	4,059
Children	960,827	53	2.686	24	2,796

source: http://kff.org/state-category/medicaid-chip/

North Carolina should seek a waiver to use federal money available for Medicaid expansion to create a modified "private insurance option" that includes the setting up of a Basic Health Plan (BHP) under section 1331 of the Affordable Care Act. When coupled with the promising regionalized Medicaid reform map that was recently previewed by the Medicaid Advisory Commission, we could set up a new system for newly covered low income persons under which insurers and providers take on more risk, moving us away from fee for service and paying for volume, and towards purchasing based on outcomes.

We could start with newly covered persons in the BHP, but over time, we could transition existing Medicaid beneficiaries who are children and adults to this basic health plan structure, or we could decide to do this more rapidly. The BHP would be a part of our State-run health insurance exchange. Multiple private insurance plans could set up networks and offer coverage, and large delivery systems could offer such plans at risk in their geographical part of the State. A few ideas for discussion:

- Persons from 0 to 100% of poverty could be enrolled by default into their counties lowest cost BHP option; we could provide them choice of plan, but it is unlikely a waiver will grant permission to charge a premium below 100% of poverty.
- Persons from 101%-200% of poverty could also be auto-enrolled in the lowest cost BHP available in their county, but could choose to be enrolled in another BHP option after paying any premium add on associated with their choice. Alternatively, residents over 100% of poverty could choose a private health insurance plan (Bronze, Silver etc.) offered in the State based insurance exchange with premiums determined on a sliding fee basis.
- The existence of a BHP set of options will lessen so called "churn" between Medicaid and a private exchange plan for persons whose incomes could go above and below Medicaid eligibility levels; 200% of poverty is around $23,000 for an individual and $47,000 for a family of 4).
- Eventually, we could end the traditional Medicaid program with private plans providing insurance for the coverage groups children and adults, with appropriate safeguards that will be front and center in any waiver negotiation; I do not think we should undertake large coverage changes in the disabled and dual eligible Medicaid populations in the first few years.
- The auto enroll BHP could be based on access to the Community Care North Carolina (CCNC) network and an integrated set of health care providers, leveraging the delivery system that exists in different parts of the state, centered on our excellent academic teaching and large hospital systems for referral services. Developing a BHP option will require going beyond what CCNC now does, as they receive capitated payment for primary care services only; currently, when referrals are made for specialty care it is billed on a fee for service basis to Medicaid. That would change under what I have outlined, and the goal is to move toward fully capitated, two-sided risk based payments to insurance companies or directly to geographically appropriate integrated delivery networks.
- Private insurance companies could put together networks and offer bids for BHP coverage in the State run exchange, and providers including CCNC and our State's great academic/referral systems could put together their own risk based contracts for residents in their geographical area, based on the emerging regional Medicaid reform map. For many reasons, I would favor in-state approaches (be they traditional insurance, or plans directly offered by delivery systems) so that the fruits of any success could remain in North Carolina. This is a personal preference.
- The BHP has the same basic benefit package as do private insurance plans sold in exchanges. Waiver authority will be needed to put persons who otherwise would be eligible for Medicaid into this private option (certainly anyone below 100% of poverty).

State flexibility in the ACA is a feature, not a bug, and the Obama Administration's desire for States to move ahead with their own approaches is apparent in their approval of the Arkansas private option, and their approval or working with other states on emerging plans. Simply put, a Republican-run State has a great deal of leverage. We should try and imagine the health system we want to move toward, and then use our this political leverage and the resources available to us in 2014 and beyond to begin moving in our preferred direction, thereby improving our own system and serving as a national model for reform.

II. Pilot Medical Malpractice and Patient Safety Reforms in Medicaid/Basic Health Plan

Our State should address the related problems of medical malpractice and patient safety by piloting a "no fault, reverse engineer to prevent" approach to medical malpractice and medical errors on a pilot basis in the Medicaid and BHP program. The experience gained could be used to fully overhaul the current medical malpractice/patient safety system that we now have in North Carolina.

A successful malpractice system would protect patients from harm via a deterrent effect of lawsuits, compensate patients for harm and exact justice. In addition, a good system would protect physicians from frivolous suits, identify substandard physicians so that medical licensure boards could remediate them or remove their licenses and provide a clear signal to insurers regarding the risk of insuring a physician.

Our malpractice system does none of these well. Nationally, 4 in 10 lawsuits are filed when there is no evidence of physician error, much less malpractice. However, in only 2 of 100 cases of truly negligent care is a lawsuit filed. And patients typically receive only half of the judgments when the system does identify truly negligent care. National estimates suggest that medical errors are a top 10 leading cause of death in the U.S., and worries about malpractice suits are a real psychic burden on providers, and are also likely to be used as a retort—what about malpractice?—for any cost control mechanism that leads to attempts to root out inappropriate care.

Caps on damages have not been shown to be particularly consequential reforms on health care costs in other states (they do decrease malpractice insurance premiums, but that is not the only goal of reform), and they do not focus on the patient safety side of the equation. Stanford Business School Professor Daniel Kessler suggests several balanced reforms.

- Clinical guideline based defense where providers can appeal to the following of best practices as an affirmative defense against malpractice suits. Such protections are actually increased in feasibility through a geographically based system of providing care such as what is suggested above because provider/network organizations have an incentive to incentive the following of such guidelines.

- Enterprise liability in which malpractice liability would be shifted from an individual provider to a hospital, network, or health delivery organization. This would incentivize such large organizations to police their own employees or members of their network.

- A more radical change is the move toward an administrative based "no fault" approach that identifies harm, compensates the harmed patient, and seeks to learn from bad outcomes to learn how to improve patient safety.

Conceptually, I believe that we need to move toward investigation and compensation for patient harms in a way that is similar to plane crash investigations. Immediate payment to the injured patient (in the case of plane crash, typically to the estate of passengers), the thorough investigation of what went wrong with a goal of reverse engineering the incident to improve safety going forward. The place where the analogy breaks down is that in most plane crashes the pilots are dead; with medical malpractice and patient safety we need for providers to be able to continue practicing medicine. The University of Michigan Medical Center has an approach to medical malpractice and patient safety that

is the closest to what I would like to move toward; can we do something like this across North Carolina? It would be hard, but it is a worthy objective.

Regardless of the exact nature of the reforms that are decided upon, North Carolina should use the occasion of expanding health insurance coverage via the "private option" Medicaid/BHP programs to test new models of addressing medical malpractice and patient safety. Lessons learned can be used to improve the system for the entire State down the road, and we could be a model for the nation.

III. Increase the Supply of Health Care Providers by Safely Reducing Regulation

North Carolina needs to encourage the following principle in our health care workforce statewide: health care providers of all types (MD, NP, PA, CNM, Pharmacists, Nursing Aides, etc) need to be empowered to work at the top level of what their license will allow. This means physicians working on more complicated care/cases and not spending time on tasks that others could safely and effectively do. To move toward maximizing this principle, our State needs to expand the ability of non-physician providers to practice more independently, and increasing our effective provider supply.

This can be achieved in two ways: First, increasing the allowable practice scope of non-physician providers generally. There is ample evidence that North Carolina is behind in this area and that we can reduce regulations safely and expand effective provider supply. Second, large provider organizations should be provided with increased flexibility to reimagine, and change the makeup and interaction of care teams that are targeted to what patients need. Any such demonstrations should be fully evaluated so that lessons can be learned in North Carolina and beyond.

Safely increasing the supply of health care providers is an important public policy priority regardless of what direction health reform might take. Increasing the supply of providers will help to expand access generally, and not only for those who have and will become newly insured via health reform. The impact is likely to be especially important in rural parts of the State, but will enable increased experimentation of providers and delivery organizations as we seek to increase value for the money spent in health care in North Carolina. There are many stakeholders in such an expansion of health provider supply, and many individuals and organizations with more expertise in the details than I have (such as the Cecil G. Sheps Center for Health Services Research at UNC, the Office of Rural Health, East Carolina University and related health system, Professional societies, etc).

How Will North Carolina Pay for Coverage Expansions

The ACA provides exceedingly advantageous financial terms under which States can expand health insurance coverage via Medicaid (estimates range from 375,000-500,000 newly insured in North Carolina). In 2016 alone, I estimate that by not expanding Medicaid our State would forego over $4 Billion in extra Federal dollars that year alone, while we would have to spend $390 Million (and decrease the ranks of the uninsured by ~375,000). There will never be a more financially advantageous way for our State to so greatly expand coverage.

I have proposed something a bit more complex than simply expanding Medicaid as it exists today, precisely because I want our State to take the promising regional approach to Medicaid reform that was

recently floated by the N.C. Medicaid Advisory Board and work to reform the State's health care delivery system, building on our strengths. So, I do not provide a precise cost estimate for what I propose, in part because I intend to start a conversation with this paper, and not attempt to have the last word. I don't believe the opposition to Medicaid expansion is primarily about numbers, but if wrong, I stand ready to work with anyone to answer any and all technical questions that the Governor, members of the General Assembly and others may have about the ACA financing, and the history of the Federal/State Medicaid financing shares (North Carolina pays ~35% of our current Medicaid program costs).

North Carolina needs to leverage the new Federal money into a strategic investment that will enable us to plant the seeds of an ongoing process of system-wide health reform, beginning with a restructuring of how we insure low income persons. I have proposed a Medicaid waiver and the development of a Basic Health Plan under section 1331 to bring about a more stable coverage vehicle for such persons, that when coupled with the regionalized approach to Medicaid reform that is being discussed, can help us move away from fee for service paying for volume, and toward paying for quality. This will help our entire system, and serve as a model for the rest of the nation.

Two Final Thoughts on Long Run Reforms

I understand that many people have legitimate and heartfelt worries about the sustainability of the federal budget, and they worry that more subsidy of health insurance is the wrong step. In my 2012 book *Balancing the Budget is a Progressive Priority*, I noted that a health reform deal between Democrats and Republicans (and everyone else) was needed for us to transition from health policy as a political football, to the practical implementation of changes, some of which will work while others will not. The reform I suggest would represent North Carolina coming together and moving to the fore in leading the way in health reform.

If we managed to agree on a way forward, I want to suggest two longer run changes that are worth considering, and that more directly address the Federal side of the health care cost problem.

- Imagine a Medicaid waiver in which the cost of the dual eligible beneficiaries (those covered by Medicare and Medicaid) are federalized to reduce the perverse incentives inherent with two payers of care; state cost savings could be used to expand insurance coverage
- Pilot a premium support approach to the setting of premiums for Medicare advantage plans in North Carolina, two to three years after we begin a State-run insurance exchange with the Medicaid waiver/BHP expansion I suggest

Propose a trade with the federal government in Medicaid. Over time we could focus our state level health policy efforts toward health insurance coverage to low income persons who are not disabled, nor also eligible for Medicare (dual eligibles). We could suggest federalizing the full cost of the dual eligibles, and in return, we could plow state savings from such a trade into our efforts to provide all persons with health insurance.

The primary reason to do this is to end the perverse incentives that arise because both Medicare and Medicaid are responsible for different aspects of the dual eligible's care; Medicare for medical services

and Medicaid primarily for long term care including nursing home coverage. Having one payer would be more likely to align incentives with high quality care for this most vulnerable and very expensive group. There are risks to such a large change, but some reform that removes the perverse incentive of two payers for such sick and complex patients is needed. A smaller scale way to work on this is via Special Needs Plans that are a subset of Medicare Advantage plans that currently exist. This tag link at my blog likely has more than you ever wanted to read about the duals. The dual eligibles are among the sickest, most vulnerable members of our society. If you care about health care costs, you have to eventually come here.

Test competitive bidding in the Medicare Advantage (private insurance Medicare option) plans in North Carolina's State run exchange. The current Medicare Advantage program sets the premiums that Medicare pays to private plans based primarily on historical spending patterns of traditional Medicare; hence, more plans are available in high spending areas, and we almost certainly overpay private plans. Around 30% of current Medicare beneficiaries have picked private plans. Requiring private plans to competitively bid for the premium they will accept to care for a Medicare beneficiary would represent a test of the preferred reform that is often associated with Rep. Paul Ryan (R-Wisconsin). The bidding process that now exists in the ACA exchanges is far closer to competitive bidding than is the current means through which premiums for Medicare Advantage plans are set. By testing competitive bidding in Medicare Advantage plans we could move toward a potential "one exchange" approach to premium supported health insurance. In the current political gridlock, some Democrats love the ACA and hate Ryan's plan, and vice-versa, when in fact, they are cousins. North Carolina could rise above this and provide a test of competitive bidding in Medicare, and do so in that way that could help the entire nation address Medicare costs via our State's experience. The competitive bidding idea has a long intellectual lineage in both political parties, as the AEI report by Feldman, Dowd and Coulam describe.

These are some of my ideas to move North Carolina ahead in health reform. I look forward to yours.

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This document has imbedded links to blog posts and other resources instead of references; if you are reading a hard copy, the electronic version available from www.donaldhtaylorjr.com has hypertext links.

Further Reading/Questions

Didn't you write a series of columns on health reform for the News and Observer? Yes all 29 are here http://sites.duke.edu/donaldhtaylorjr/favorite-no-blgs/

Who is covered by Medicaid in North Carolina? http://donaldhtaylorjr.wordpress.com/2013/05/22/n-c-s-nascent-medicaid-reform-plan-ii-who-is-covered-by-medicaid/?

How much money is North Carolina foregoing by not expanding Medicaid? http://donaldhtaylorjr.wordpress.com/2013/10/26/self-imposed-redistribution-from-poor-to-rich-states/

Who are the dual-eligibles (covered by Medicare and Medicaid)? http://donaldhtaylorjr.wordpress.com/2013/06/07/n-c-s-nascent-medicaid-reform-iv-the-dual-eligibles/

Are the administrative costs for North Carolina's Medicaid program high? http://donaldhtaylorjr.wordpress.com/2013/11/25/n-c-medicaid-administrative-costs/

Do only poor people get subsidies for their health insurance? http://donaldhtaylorjr.wordpress.com/2013/11/16/how-much-subsidy-should-each-person-get-for-health-insurance/

Are premiums for private health insurance higher in States where fewer companies sell policies? http://donaldhtaylorjr.wordpress.com/2013/10/11/premiums-higher-where-less-competition-what-can-be-done/

How do you want your children to get health insurance in 20 years? http://donaldhtaylorjr.wordpress.com/2013/08/30/how-do-you-want-your-children-to-get-health-insurance-in-20-years/

Isn't there a new Medicaid Advisory Panel in North Carolina? http://donaldhtaylorjr.wordpress.com/2013/08/05/north-carolinas-nascent-medicaid-reform-vii-new-advisory-panel/ and http://donaldhtaylorjr.wordpress.com/2013/12/06/north-carolina-medicaid-reform-reset/

How much would it cost North Carolina to ensure someone via Medicaid expansion? http://donaldhtaylorjr.wordpress.com/2013/07/19/how-much-would-it-cost-north-carolina-to-insure-someone-via-medicaid-expansion/

What is Long Term Care? http://donaldhtaylorjr.wordpress.com/2013/06/27/cbo-on-long-term-care/

Don't the uninsured get anything they want in the ER? http://donaldhtaylorjr.wordpress.com/2012/04/09/diaz-v-north-carolina/

How should people in North Carolina think about that new Medicaid study from Oregon? http://donaldhtaylorjr.wordpress.com/2013/05/06/how-should-north-carolina-think-about-the-oregon-medicaid-study/

How much subsidy do people in different groups get for their health insurance? http://donaldhtaylorjr.wordpress.com/2013/11/16/how-much-subsidy-should-each-person-get-for-health-insurance/